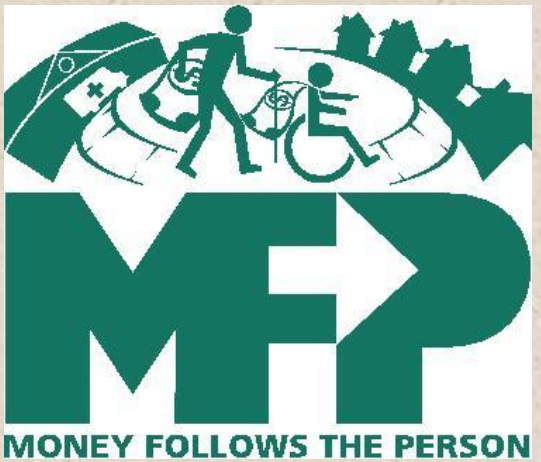


Rebalancing Demonstration

California Community Transitions ~ CCT ~

Person Centered Planning / CCT Assessment & Care Planning Webinar

September 2014

http://dhcs.ca.gov/cct

Training Module 1

Options Counseling & Person Centered Planning

Identification & Counseling

Stages of Change

- The transition process is driven by each person's motivation and self-confidence for making a major life change by moving from institutional living to his/her home community.

- A framework for supporting the consumer is suggested by Prochaska, J. O, et.al. in *Stages of Change and Decisional Balance*. These stages of making change set the framework:

  - **Pre-Contemplation**
  - **Contemplation**
  - **Preparation**
  - **Action**
  - **Maintenance**

Prochaska, J. O., Velicer, W. F., Rossi, J. S., Goldstein, M. G., Marcus, B. H., Rakowski, W., Fiore, C., Harlow, L. L., Redding, C. A., Rosenbloom, D., & Rossi, S. R. (1994). for twelve problem behaviors. *Health Psychology, 13*, 39-46.

Communication Techniques

What is Motivational Interviewing (MI)?

- **Motivational Interviewing** is a method that works on facilitating and engaging intrinsic **motivation** within the client/consumer in order to change behavior. MI is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

https://www.youtube.com/watch?v=s3MCJZ7OGRk

An Introduction to Motivational Interviewing: Bill Matulich

Communication Techniques (continued)

Active Listening & Roadblocks to Communication

Active Listening Skills

- Restating
- Summarizing
- Minimal encouragers
- Reflecting
- Giving feedback
- Emotion labeling

Communication Techniques (continued)

Active Listening & Roadblocks to Communication

Communication Blockers

- These roadblocks to communication can stop communication dead in its tracks
  - **"Why" questions**
  - **Quick reassurance**
    - **"**Don't worry about that"
  - **Advising**
    - "I think the best thing for you is to move to assisted living"

<Source: Excerpted and adapted from Lee Scheingold, "Active Listening," McKesson Health Solutions LLC, 2003.>

Communication Techniques (continued)

Active Listening & Roadblocks to Communication

Communication Blockers (continued)

- Digging for information
  - Forcing someone to discuss something they don't want to
- Patronizing
  - "You poor thing, I know just how you feel."
- Preaching
  - "You should (or shouldn't)…"
- Interrupting

Person-Centered Planning

- The PCP approach identifies the **person's strengths, goals, preferences, needs (medical and HCBS), and desired outcomes**.

- The role of transition coordinator in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs, and provide support during planning.

- The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are **part of a written plan** that is consistent with the person's needs and desires.

Person-Centered Planning (continued)

- The PCP approach identifies the person's strengths, goals, preferences, needs (medical and HCBS), and desired outcomes.

- The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments **are part of a written plan** that is consistent with the person's needs and desires.

Face-to-Face training available to CCT Lead Organizations

The two day face-to-face training covers detailed information on motivational interviewing, person-centered planning, communication techniques and other skills important to transition.

Contact: Ed.Ahern@aging.ca.gov for more information

Dignity of Risk

"Dignity of Risk" refers to the consumer's right to make an informed choice to experience life and take advantage of opportunities for learning, developing competencies and independence and, in doing so, take a calculated risk.

The concept means that all adults have the right to make their own choices about their health and care, even if health care professionals believe these choices endanger the person's health or longevity.*

Dignity of Risk (continued)

Respect the Dignity of Risk

- Every person needs enough control within their lives to choose what they value and reject what they do not
- Health care professionals may try to move away from this when patients are elderly or have disabilities
- Follow-up and treatment plans must respect what is important to the person

Transition Coordination & Service Planning

Action Plan

- An Action Plan is a tool developed as a result of a person-centered interviewing process between the individual needing LTSS and the transition coordinator. The process includes assisting the LTSS consumer with weighing the pros and cons of various services.

- Action Plan identifies consumer goals (both short and long term) and the steps the consumer (and the transition coordinator) will take to reach those goals.

http://communitychoices.info/OC/workgroup-documents/documents/MFP_Action_Plan_FormOnly_12-7-2013.doc

Action Plan (continued)

- Topics of Discussion
- What's Important: Goals (short and long term)
- Steps to achieve goal (both for consumer and transition coordinator)
- Action Plan is a tool for empowerment

Action Plan (continued)

Transitions Options Counseling Action Plan

Name: _____ **Date:** January 1, 2014

Transition Options Counseling is the process where you help me understand what's important to you as we begin to plan your transition back into the community. Transition Options Counseling ends with a list of things we will both be doing as 'next steps' in your transition process.

☐ We have discussed the importance of your participation in the transition process.

Prior Military Service Yes No

During this Options Counseling session we spoke about: *(while many of these subjects may need to be discussed as part of your transition plan, you may wish to focus on some of the most important (housing, benefits/programs, documents) at the beginning.)*

☐ Housing	☐ Personal Assistance	☐ Benefits/Programs
☐ Assistive Technology	☐ Peer Mentoring	☐ Skills Training
☐ Documents (SS Card, DMV)	☐ Mental Health Supports	☐ Addiction Supports
☐ Social/Faith, and Recreation	☐ Community Integration	☐ Food/ Meal Programs
☐ Family and Friends Support	☐ Transportation	☐ Mental Health Services
☐	☐ Volunteering/Employment	☐ Veteran Issues
☐ _____	☐ _____	☐

Action Plan (continued)

Goals: After talking with you, I understand that you want to move back to the community:

My 3 most important goals after transitioning are:
I want/need …
I want/need …
I want/need …

The 3 most important things it will take for me to move out are:
I want/need …
I want/need …
I want/need …

Three other things that are also important to me as/after I transition are:
I want/need …
I want/need …
I want/need …

Action Plan (continued)

Action Steps:

What
Who
Details:

By (date)

What
Who
Details:

By (date)

What
Who
Details:

By (date)

What
Who
Details:

By (date)

ADLs/IADLs

What are activities of daily living (ADLs)?

Activities of daily living (ADLs) are basic self-care tasks, akin to the kinds of skills that people usually learn in early childhood. They include the following:

- Feeding
- Toileting
- Selecting proper attire
- Grooming
- Maintaining continence
- Putting on clothes
- Bathing
- Walking and transferring (such as moving from bed to wheelchair)

- ✓ ADLs are often mentioned by geriatric-care professionals in connection with instrumental activities of daily living (IADLs; see below), which are slightly more complex skills.
- ✓ ADLs are occasionally referred to as basic activities of daily living (BADLs).

ADLs/IADLs (continued)

What are instrumental activities of daily living (IADLs)?

Instrumental activities of daily living (IADLs) are the complex skills needed to successfully live independently. These skills are usually learned during the teenage years and include the following:

- Managing finances
- Handling transportation (driving or navigating public transit)
- Shopping
- Preparing meals
- Using the telephone and other communication devices
- Managing medications
- Housework and basic home maintenance

✓ Together, ADLs and IADLs represent the skills that people usually need to be able to manage in order to live as independent adults.

✓ Doctors, rehabilitation specialists, geriatric social workers, and others in senior care often assess ADLs and IADLs as part of an older person's functional assessment. Difficulty managing IADLs is particularly common in early Alzheimer's and other dementias. Assessing IADLs can help guide a diagnostic evaluation, as well as determine what kind of assistance an older person may need on a day-to-day basis.

Training Module 2

Beneficiary Assessment

Relationship building with SNFs

- Nursing facilities (NF) are aware of the CCT demonstration.
- Each facility is unique and may or may not provide welcome to CCT Transition Coordinators visiting residents without being invited.
- While residents are free to have visitors, it is prudent to do some fact finding and provide general education to each facility Administrator and Director of Nurses.
- Gather information about each facility and keep on file information about location, staff contact numbers and other details on each facility in the area.
- http://communitychoices.info/OC/workgroup-documents/documents/NursingHomeFacilityInformationSheet.doc - Nursing Home Info. Sheet

Process

Steps	Deliverable(s)		State Approval	Outcome	CCT Lead Organization Performance Measures
	Keep On-site	Submit to State			
1. **Outreach and Targeting** • Develop relationships with area SNF and MCHP (not required) • Receive a list of names of people requesting more information about community integration (MDS, Section Q)	○ CCT LO – MCHP contracts ○ MDS Referral Tracking Log	☐ ***Monthly Report*** • *CCT Monthly Data Report* • *CCT Monthly Report Summary* • *CCT Monthly Event/Issue Report* ☐ **Tracking Data Sheet for MDS 3.0 Section Q Referral Encounters**		Recognition and on-going business relationships; sustainable network of service providers	
2. **Information Gathering** • Conduct an initial interview with consumer. • For interested beneficiaries who sign the ***CCT Enrollees'/Participants Rights & Responsibilities/Consent Form & Authorization for Release of Protected Health Info.***, TC will collect records necessary to conduct local-level Clinical Assessment. ***CCT Assessment Tool*** ○ LO's RN completes clinical assessment on beneficiary ***CCT Initial Transition and Care Plan*** ○ developed with the majority of needs, services, and supports identified	• ***Authorization for Release of Protected Health Info*** • ***CCT Enrollees'/Participants' Rights & Responsibilities/Consent Form*** o ***24-7 Back-up Plan*** o ***Independent Housing Disclosure*** o *Copy of the signed Lease Agreement*	☐ ***CCT Assessment Tool*** ☐ ***CCT Initial Transition and Care Plan*** ☐ ***CCT NEI Form (& Facility Face Sheet)*** Assessment & Planning **TAR**	• $908.60 "dollar amount" for TC	1. Beneficiary is enrolled in CCT ☐ ***CCT Assessment Tool, CCT Initial Transition and Care Plan and CCT NEI Form (& Facility Face Sheet)*** 2. submitted to DHCS NE for review 3. LO will receive TC hours for work performed if all documentation is provided, regardless of NEII approval.	1. Ratio between the number of beneficiaries who were referred to CCT, and the # of those individuals who signed the ***CCT Enrollees'/Participants' Rights & Responsibilities/Consent Form*** to enroll in CCT

Process (continued)

Steps	Deliverable(s)		State Approval	Outcome	CCT Lead Organization Performance Measures
	Keep On-site	Submit to State			
3. **DHCS Nurse Evaluator (NE) Review** ☐ Clinical Review of Enrollee's ***CCT Assessment Tool, CCT Initial Transition and Care Plan and CCT NEI Form*** ***(& Facility Face Sheet)*** • (with all necessary supporting documentation)			• 100 hours of TC		1. Ratio between the # of beneficiaries enrolled in CCT, and the # those determined to be transition-able by DHCS NEs 2. Maximum, minimum, and average costs of individuals who do not get approved by DHCS NEs
4. **Implementation** ***CCT Final Transition and Care Plan*** • Work with Enrollee, Legal Representative (if applicable), facility discharge planner, MCHP representative, LO RN, & LO TC to develop a ***CCT Final Transition and Care Plan*** that addresses the individual's unique medical and socio-economic needs in the community • Identify & secure appropriate and available HCBS, housing, in home support worker(s), etc.	• Any additional supporting documentation *(keep on site and provide copy to consumer)*	☐ ***CCT Final Transition and Care Plan***, including: ☐ Home Set-Up **TAR** ☐ Home Modification **TAR** ☐ Vehicle Adaptation **TAR** ☐ Assistive Devices **TAR** ☐ Habilitation **TAR** $11.36 / 15 minutes ($45.44 / hour) ☐ ***Baseline QOL***	• Home Set-up $ based on qualified housing arrangement (3 month lifespan) • Home Modification, up to $7,500 (3 month lifespan) • Vehicle Adaptation, up to $12,000 (9 month lifespan) • Assistive Devices, $7,500 (9 month lifespan) • Habilitation $11.36 / 15 min. ($45.44 / hour)	HCB LTSS identified, secured, & ready to implement safe and sustainable transition	1. Ratio between the # of beneficiaries determined to be transition-able by DHCS NEs, and the # those who actually transition to the community 2. Maximum, minimum, and average costs of transition coordination hours for individuals (approved by DHCS NEs) who do not end up transitioning to the community 3. Required CCT documents are being provided to the beneficiary are easily accessible (physically and cognitively) at home/ place of residence

Process (continued)

Steps	Deliverable(s)		State Approval	Outcome	CCT Lead Organization Performance Measures
	Keep On-site	Submit to State			
3. **Follow-Up** • Collaborate with other service providers to ensure a smooth transition to IHSS Social Worker, MCHP Case Manager, or HCBS Case Manager • Review the ***CCT Final Transition and Care Plan*** with the participant and address any needs &/or concerns • Explain that the CCT project ends on day 365, but that existing services will continue as long as the person remains eligible for HCB Medi-Cal services	• Case Management notes	☐ Signed ***Day of Transition Report Form*** ☐ Follow-Up TC **TAR** ☐ ***Follow-Up QOLs*** x 2 ○ Month 11 ○ Month 24	• # hours of post-transition services (see table next page)	The goal(s) of requiring on-going TC contact with transitioned CCT Participants is to provide: 1. Support/resources necessary to address changes in health status; 2. Address previously unidentified needs that only became apparent after leaving the SNF; and 3. A reduced sense of isolation/abandonment after transition, and/or an increase in a person's quality of life	1. Ratio between the # of participants who drop out of the demonstration (death, return to the SNF, etc.), to the # of participants who remain in the community, and to the total # of people who were transitioned 2. Balance between the cost of transitioning individual, and the amount of money that was saved during the time the individual lived in the community

Process (continued)

Post-transition Follow-up*

PLEASE NOTE

- We envision a NEW modifier added to the existing (G9012) which would be U7 (G9012 U7) to specify that the Lead Organization is able to bill for a fixed "dollar amount" of **$908.60** for pre-TC
- DHCS envisions changing **G9012 – U6: Transitional Case Management (TCM) and S5111: Home care training, family** from (1HR. BILLING) to (Quarter HR. BILLING)

Example: Instead of an LO billing $45.43/hr. they should be able to bill for **$11.36 / 15 minutes for the services specified above.**

Service Code ➡ **Post-transition HCB Services** ⬇	**G9012 – U6: Transitional Case Management (TCM)** Coordinated care fee, risk adjusted maintenance, other specified care management. Services to transition an eligible individual from a health facility to a HCB setting. $11.36 / 15 minutes ($45.44 / hour)	**T2017 – U6: Habilitation, residential, waiver** Services to assist the CCT Participant in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in a participant's natural environment. $11.36 / 15 minutes ($45.44 / hour)	**S5111 – U6: Home care training, family** Family training services provided for the families of individuals served under the waivers. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to maintain the individual's safety at home. **HHAs only**** $11.36 / 15 minutes ($45.44 / hour)	**T1019 – U6: Personal Care Services before IHSS starts** Supportive services to assist an individual to remain at home and includes assistance to independent activities of daily living and adult companionship. $3.62 / 15 minutes ($14.48 / hour)
Informal Support / State Plan Services	<u>Months 1 – 3 after transition</u>: Face-to-face 2X / month <u>Months 4 – 12 after transition</u>: Face-to-face 1X / month Additional care coordination required for re-establishing care, if necessary	As required, (based on medical necessity) within the first 3 months after transition, capped at 50 hours	As necessary	N/A
In-Home Support Services	<u>1st Month after transition</u>: Face-to-face 2X / month <u>Months 4, 8 & 12 (Quarterly) after transition</u>: Face-to-face 1X / month <u>Months 2, 3, 5, 6, 7, 9, 10 & 11 after transition</u>: Phone call 1X / month Additional care coordination required for re-establishing care if necessary	50 hours, post-transition (based on medical necessity)	As necessary	As required, (based on medical necessity) before IHSS starts, **<u>not</u>** to exceed 40 hours per week

Process (continued)

Service Code ➡ / Post-transition HCB Services ⬇	**G9012 – U6: Transitional Case Management (TCM)** Coordinated care fee, risk adjusted maintenance, other specified care management. Services to transition an eligible individual from a health facility to a HCB setting. $11.36 / 15 minutes ($45.44 / hour)	**T2017 – U6: Habilitation, residential, waiver** Services to assist the CCT Participant in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in a participant's natural environment. $11.36 / 15 minutes ($45.44 / hour)	**S5111 – U6: Home care training, family** Family training services provided for the families of individuals served under the waivers. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to maintain the individual's safety at home. **HHAs only**** $11.36 / 15 minutes ($45.44 / hour)	**T1019 – U6: Personal Care Services before IHSS starts** Supportive services to assist an individual to remain at home and includes assistance to independent activities of daily living and adult companionship. $3.62 / 15 minutes ($14.48 / hour)
Waiver Services **NF/AH Waiver, Assisted Living Waiver,** **And other Waiver (AIDS, MSSP, SMHCP)**	Months 1, 4, 8 & 12 (Quarterly) after transition: Face-to-face 1X / month Months 2, 3, 5, 6, 7, 9, 10 & 11 after transition: Phone Call 1X / month	50 hours, post-transition (based on medical necessity)	N/A	N/A

* The hours allocated in this chart are the maximum number allowed for each post-transition service package; if additional hours are required based on individual needs &/or circumstances, submit a request for approval of additional hours with a detailed explanation to the assigned state Nurse Evaluator (NE).

** This service code may only be used by Home Health Agencies to train care takers on how to provide medical treatments and maintenance, and the services must be reviewed and approved by state NEs before any training is provided.

CCT Assessment Tool

California Community Transitions (CCT) Assessment Tool

CCT Lead Organization
Assessment completed by
Assessment completed on

SECTION A: DEMOGRAPHIC INFORMATION

1. Enrollee's full legal name

First | M.I. | Last | Suffix

2. MediCal number

3. Medicare number:

4. Sex

5. Date of birth

6. Marital status

- Married
- Single
- Divorced
- Widowed
- Separated
- Significant other

7. Ethnicity

- African-American
- American Indian or Alaska Native
- Asian
- Caucasian
- Hispanic or Latino
- Pacific Islander
- Decline to state
- Other

SECTION B: COGNITIVE PATTERNS

1. Memory / Recall (check EACH item the individual was able to recall in the past 7 days)

- ◯ Current Season
- ◯ Location of own room
- ◯ Names/Faces
- ◯ Current Residence
- ◯ None of the Above

2. Memory and Use of Information (check only ONE option)

- ◯ The individual does not have difficulty remembering and using information. Does not require directions or reminding from others.
- ◯ The individual has minimal difficulty remembering and using information. Requires direction and reminding from others 1 to 3 times per day. Can follow simple written instructions.
- ◯ The individual has difficulty remembering and using information. Requires direction and reminding from others 4 or more times per day.
- ◯ The individual cannot remember or use information. Requires continual verbal reminding.

3. Cognitive Skills for Daily Decision-Making / Judgment and Ability to Make Decisions Regarding Daily Life Tasks (check only ONE option)

- ◯ Independent – decisions consistent/reasonable
- ◯ Modified Independence – some difficulty in new situations only, judgment sometimes impaired
- ◯ Moderately Impaired – usually not able to make decisions, judgment

SECTION C: PHYSICAL FUNCTIONING

1. ADL Self-Performance. Code for individual's performance during the last 7 days with or without assistive device(s):

(0) Independent = No help or oversight, and/or help/oversight 1 – 2 times in the last 7 days.

(1) Supervision = Oversight, encouragement, cueing or set-up assistance provided 3 or more times during the last 7 days and/or physical assistance provided 2 times during last 7 days.

(2) Limited Assistance = Individual highly involved in activity, received physical assistance 3 or more times and/or extensive assistance provided only 1 or 2 times during the last 7 days.

(3) Extensive Assistance = Extensive assistance provided 3 times/week and/or full performance of task by others during part, but not all of last 7 days.

(4) Total Dependence = Full performance of activity by others during entire 7 days.

- (a) Bed Mobility – How the individual moves and positions self.
- (b) Transfer – How the individual moves between surfaces.
- (c) Locomotion in Residence – How the individual moves in his/her room and other areas in the facility.
- (d) Dressing – How the individual puts on, fastens, and takes off clothing, including donning/removing prosthesis.

SECTION D: COMMUNICATION / HEARING PATTERNS / VISION PATTERNS

1. Hearing Patterns – Ability to hear, with aid if used (check only ONE option)

- ◯ Hears adequately (normal talk, TV, phone)
- ◯ Minimal difficulty (when not in quiet setting)
- ◯ Hears in special situations only (speaker has to adjust tonal quality and speak distinctly)
- ◯ Highly impaired (absence of usual hearing)

2. Communication Devices or Techniques (check ALL that apply)

- ◯ Hearing aid present but not used regularly
- ◯ Other receptive communication techniques used (e.g. lip reading)
- ◯ Hearing aid needed; or if currently being used needs to be reevaluated
- ◯ Hearing aid present and used regularly
- ◯ No device

3. Modes of Expression (check ALL that apply)

- ◯ Speech
- ◯ Writing messages to express or clarify needs
- ◯ American sign language or Braille
- ◯ Signs/gestures/sounds
- ◯ Communication board

SECTION E: DIAGNOSIS

1. Active Diagnosis

Check ALL active diagnosis that apply:

a. ENDOCRINE/METABOLIC/NUTRITION

- Diabetes mellitus
- Hyperthyroidism
- Hypothyroidism

b. HEART/CIRCULATION

- Arteriosclerotic heart disease
- Cardiac dysrhythmias
- Congestive heart failure
- Deep vein thrombosis
- Hypertension
- Hypotension
- Peripheral vascular disease
- Other cardiovascular disease

SECTION F: MEDICATIONS

1. Is the individual allergic to any medication?

   ○ No ○ Yes (please specify belolw)

2. Enter the total number of medications taken by the individual including prescribed medications and other over-the-counter medications (includes pm and as-needed medications). ☐

Complete the rest of this section if the individual is taking medication.
Skip to the "Oral/Nutritional Status" section if the individual is not taking any medication.

3. List all current medications

Medication	Dosage	Route	Frequency

SECTION G: ORAL/NUTRITIONAL STATUS

1. Has the individual had significant (10%) weight loss or gain in the past 6 months?
   a. Weight Loss
   b. Weight Gain

2. Is the individual on a special diet? (check ALL that apply)
   - ◯ No restrictions
   - ◯ Restrictions:(Check all that apply):
     - ◯ Mechanically altered or pureed
     - ◯ Vegetarian
     - ◯ NO salt
     - ◯ Restricted items (specify):
     - ◯ Diabetic
     - ◯ Low Sodium
     - ◯ Kosher

3. Does the individual have any food allergies?If yes, specify:

SECTION H: SKIN CONDITION

1. Ulcers – record the number of ulcers at each ulcer stage, regardless of cause

Stage 1 A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved

Number of ulcers:

Location:

Stage 2 A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater

Number of ulcers:

Location:

Stage 3 A full thickness of skin lost, exposing the subcutaneous tissues, presents as a deep crater with or without undermining adjacent tissue

Number of ulcers:

Location:

Stage 4 A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone

Number of ulcers:

Location:

SECTION I: OTHER TREATMENT/PROCEDURE/PROGRAMS

1. Current Treatments Received at the Facility

		Able to Self-Manage	Needs Assistance
a.	Oxygen		
	Gas: ◯ Intermittent ◯ Continuous	◯	◯
	Liquid ◯ Intermittent ◯ Continuous	◯	◯
b.	Blood sugar tests	◯	◯
	Frequency:		
c.	Urinary catheter care	◯	◯
d.	IPPB machine / nebulizer	◯	◯
e.	Colostomy	◯	◯
f.	Ileostomy	◯	◯
g.	Tracheostomy care	◯	◯
h.	Gastrostomy care	◯	◯
i.	Enemas/suppositories	◯	◯
j.	Other (specify):	◯	◯

SECTION J: ASSESSMENT INFORMATION

1. Did the individual participate in the completion of this assessment?

2. Did the individual's family participate in the completion of this assessment?

3. Did the individual's Legal Representative participate in the completion of this assessment?

4. Did anyone else participate in the completion of this assessment?

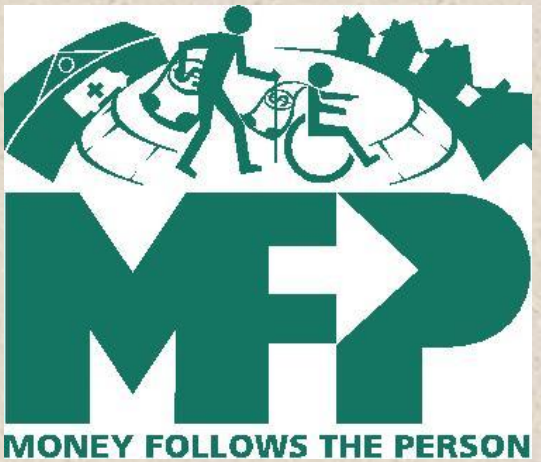
If "Yes," specify:

SECTION K: MOOD AND BEHAVIOR PATTERNS

1. Indicators of Depression, Anxiety, Sad Mood
Select the best description for each of two factors: Frequency and persistence.

a. Verbal Expressions of Distress or Anxiety

	Frequency	Persistence
Made negative statements		
Repetitive questions		



Rebalancing Demonstration

California Community Transitions ~ CCT ~

Person Centered Planning / CCT Assessment & Care Planning Webinar

September 2014

http://dhcs.ca.gov/cct

Training Module 2 (continued)

Initial & Final Care Planning

HCBS Waivers/
Programs/Services

IHSS

Nursing Home
Resident

Employment

Community

AT/DME

Health
Care
Services

Community
Services

Independent
Living Centers

Transition and Care Plan (TCP) Putting the pieces together

Health Care Services
- Plan of Treatment (POT)
- Nursing Care Services
- Nutrition Services
- Allied Health/Other Therapies
- Durable Medical Equipment and Supplies

Supportive Services
- Family/Support Persons
- Personal Attendants
- Emergency Back-up
- Housing
- Transportation

Social Services
- Peer Support/Mentoring
- Recreation/Cultural Connections
- Spiritual Connections

Environmental Services
- Home & Vehicle Modification
- Assistive Technology
- Household Set-up

Education/Training Services
- Independent Living Skills
- Attendant Training/Management
- Emergency Planning
- Caregiver Training

Financial Services
- Medi-Cal Codes
- Money Management
- SSI/SSP payments

Other Services
- Employment Services
- Demonstration Services
- Supplemental Services

Transition and Care Plans (TCPs)

- TC meets with enrollee to gather information on service and care needs for community living.
- Enrollee and TC design two Transition and Care Plans (TCPs) listing enrollee's needs and services designed to meet those needs.
- TC determines if transition to community living is feasible, providing for resident's health and welfare.
- Enrollment information and TCPs are submitted to CCT Project staff.

Transition and Care Plan (TCP)

<u>Initial</u> (I-TCP)

Submitted Pre-Transition with CCT Assessment Tool, New Enrollee Info. (NEI) Form & Facility Face Sheet. Signed by Enrollee & RN.

<u>Final</u> (F-TCP)

Submitted documenting LTSS in place prior to enrollee's transition. Signed by Enrollee, RN and Physician.

CCT INITIAL Transition and Care Plan

California Community Transitions (CCT)
Initial Transition and Care Plan

CCT Lead Organization:

Form Completed by:

Enrollee's Legal Name:

Medi-Cal Number:

Date of Birth:

Targeted Date of Transition:

Preferred Housing Option:

- ◯ Return to Own Home
  - ◯ Alone
  - ◯ With Family
  - ◯ With Others
- ◯ Independent Housing (including public housing)

Anticipated Plans for Care:

	Intervention	Goal of Intervention	Proposed Provider
Medical Care			
On-going Nursing Care			

Type response

	Intervention	Goal of Intervention	Proposed Provider
On-going Supervision			

	Intervention	Goal of Intervention	Proposed Provider
Therapies			

Durable Medical Equipment (DME):

What type(s) of DME will be required outside of the inpatient facility? (check all that apply):

- ◯ Power Wheelchair
- ◯ Manual Wheelchair
- ◯ Grab Bars
- ◯ Bedside Commode
- ◯ Shower Chair
- ◯ Hand-held Shower Nozzle
- ◯ Other (please list)

Environmental Services:

What type(s) of Home & Vehicle Modifications, Assistive Technology, and/or Household Set-Up will be required outside of an inpatient facility? (check all that apply):

Risk Assessment:

List potential areas of concern or issues which need to be addressed prior to enrollee's/participant's transition.

Examples: History of substance use (alcohol or drugs), minimal family support, risk of re-institutionalization, etc.

Common Areas of Concern (check all that apply):

- ◯ Re-institutionalization
- ◯ Homelessness
- ◯ Isolation
- ◯ Substance Use
- ◯ Other:

RISK #1:

Steps to be taken to prevent or mitigate occurrence of problem:

Option 2:

The Initial Transition and Care Plan developed for this individual sufficiently addresses his/her medical needs identified in the CCT Clinical Assessment.
Signatures of Persons Approving this Initial Transition and Care Plan:

Transition Coordinator (TC) Signature	Date
CCT Enrollee's Signature	Date
Legal Representative/Conservator's Signature (if applicable)	Date

Select one of the two options below, read it, and if it is correct, sign.

Option 1:

The Initial Transition and Care Plan developed for this individual does not sufficiently address his/her medical needs as identified in the CCT Clinical Assessment at this time.

By signing below, I understand that the CCT transition process cannot move forward until an Initial Transition and Care Plan has been developed that addresses all of the individual's medical needs, as identified in the CCT Clinical Assessment, in the community.

Transition Coordinator (TC) Signature	Date
CCT Enrollee's Signature	Date
Legal Representative/Conservator's Signature (if applicable)	Date

CCT FINAL Transition and Care Plan

California Community Transitions (CCT)
Final Transition and Care Plan

CCT Lead Organization:

Form Completed by:

Enrollee's Legal Name:

Medi-Cal Number:

Date of Birth:

Date of Scheduled Transition:

List key changes since assessment and initial CCT transition and care plan:

Primary care physician

Name

Phone

Address

Type response

Post-transition care plan

Health Care Services (check all that apply)

- Managed care health plan
- Nursing home or acute hospital (NF/AH) waiver. Level:
- In-home support services (IHSS). Number of authorized hours:
- AIDS waiver
- SCAN
- Cal Medi-Connect
- Multi-purpose senior services program (MSSP)
- Program of All-inclusive Care for the Elderly (PACE)
- Assisted living waiver (ALW)

Health care providers (check all that apply), provide names and phone numbers:

- ◯ Home health agency
  - Name _____ Phone: _____
- ◯ Behavioral health services
  - Name _____ Phone: _____
- ◯ Mental health services
  - Name _____ Phone: _____
- ◯ Substance use prevention services
  - Name _____ Phone: _____

IHSS approved and in place

- ◯ Yes
- ◯ No
- ◯ Not applicable
- ◯ Awaiting assessment
- ◯ Hours approved, caregiver not hired yet

Household Set-Up completed before transition (check all that apply):

YES NO N/A

If no, explain what is left to accomplish:

Home Modifications completed before transition (check all that apply):

YES NO N/A

If no, explain what is left to accomplish:

Vehicle Adaptation completed before transition (check all that apply):

YES NO N/A

If no, explain what is left to accomplish:

Risk Assessment:

List potential areas of concern or issues which need to be addressed prior to enrollee's/participant's transition. For example, a history of substance use (alcohol or drugs), minimal family support, risk of re-institutionalization, etc.

Common Areas of Concern (check all that apply):

- ◯ Re-institutionalization
- ◯ Homelessness
- ◯ Isolation
- ◯ Substance Use
- ◯ Other (explain):

RISK #1:

Steps taken to prevent or mitigate re-occurrence of problem:

Signatures of Persons Completing this Final Transition and Care Plan (F-TCP)

Transition Coordinator (TC) Signature	Date
CCT Enrollee's Signature	Date
Legal Representative or Conservator's Signature (if applicable)	Date
Physician's Signature	Date

Health Care Service Plan (HCSP)

DHCS Home and Community-Based Services (HCBS) Waiver Summary

ALW

Current Tier:

Previous Tier:

ALW Residence:

HCSP: (check all that apply)

- ◯ Initial
- ◯ Semi-Annual
- ◯ Yearly
- ◯ Update
- ◯ Reason

NF/AH

Level of Care:

IHO Office: (check all that apply)

◯ North ◯ South

Intake Nurse:

Case Manager:

Date of last HCSP:

Health problem #1:

Interventions:

Goal of intervention:

Responsible provider:

Health problem #2:

Interventions:

Goal of intervention:

Responsible provider:

Health problem #11:

Interventions:

Goal of intervention:

Responsible provider:

Health problem #12:

Interventions:

Goal of intervention:

Responsible provider:

Type response

Signature of person completing the health care service plan (HCSP).

Registered Nurse (RN) Signature

Date

CCT Project Clinical Staff evaluates feasibility of transition

- If transition is feasible, resident is enrolled, and LO continues to work with individual.
- If transition is not feasible, a notice of action (NOA) is issued for denial of services.